



**Patient Information**

Patient Name: \_\_\_\_\_

First

Middle

Last

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Cell Phone:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Home Phone:(\_\_\_\_)\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Current Dentist: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Health Information**

Please list any health issues:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take any bone strengthening medication (bisphosphonates)?: \_\_\_\_\_

**Parent or Guardian Information**

Name: \_\_\_\_\_

First

Middle

Last

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Cell Phone:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Home Phone:(\_\_\_\_)\_\_\_\_-\_\_\_\_

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is this Responsible Parent/Guardian financially responsible for account charges?  Yes  No

Is this Responsible Parent/Guardian the primary person to bring the patient to appointments?  Yes  No

### Primary Dental Insurance Information

Subscriber Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber ID Number or SSN: \_\_\_\_\_ Group Number: \_\_\_\_\_

### Secondary Dental Insurance Information

Subscriber Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber ID Number or SSN: \_\_\_\_\_ Group Number: \_\_\_\_\_

### Privacy Practice Acknowledgement

I \_\_\_\_\_ acknowledge that I have received a copy of the Notice of Privacy Practices. I also acknowledge that the information above is completed correctly and to the best of my knowledge.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_